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March 5, 2018

Ajit Pai, Chairman
Mignon Clyburn, Commissioner
Michael O'Rielly, Commissioner
Brendan Carr, Commissioner
Jessica Rosenworcel, Commissioner
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

RE: Reply Comments on WC Docket No. 17-310 Notice of Proposed Rulemaking (NPRM) and Order

Dear Chairman Pai and Commissioners,

Kellogg & Sovereign® Consulting, LLC ("KSLLC") submits these Reply Comments in response to the FCC's Notice of Proposed Rulemaking and Order, released December 18, 2017.

The professionals with KSLLC have been managing RHC applications on behalf of healthcare entities since 2007 and E-rate applications since 1998. In FY 2017, KSLLC managed applications for over 600 E-rate and RHC applicants. The E-rate applicants range in size from a single building in a small rural town to large urban districts and everything in between. The RHC applicants range in size from small rural health clinics to regional consortia and large urban hospital systems.

The firm's diverse client base provides KSLLC with a unique perspective to share the successes and challenges faced by various types and sizes of applicants in securing funding from the RHC and E-rate programs. These programs are vitally important to meeting the needs of the applicants by providing affordable access to healthcare services and, in the case of schools, to curriculum resources in the cloud.

1. REVISITING THE RHC PROGRAM FUNDING CAP

15. FY 2017 Funding Cap

As Kellogg & Sovereign® Consulting, LLC (KSLLC) stated in their original comments:

> In FY 2016, the demand from both programs exceeded the $400 million cap for the first time in the Program's history, resulting in proration of support for applicants. Although funding has not yet been committed for FY2017, raw data from USAC indicates that FY2017 demand will also exceed the current $400 million cap. [1]

[1] KSLLC (2018, February 2) Comments at 2; https://www.fcc.gov/ecfs/filing/10203192372943

The NPRM asks for comments on increasing the cap for the RHC Program and whether they should retroactively increase the cap for FY 2017. KSLLC believes that the commission should, "Provide sufficient funding for(all) FY2017 approved requests." and "Take action as appropriate – as proposed in the draft NPRM, to waive the RHC Program's cap now on a one-time basis and instruct USAC to carry forward any unused RHC Program funds from prior funding years for use in FY 2017."

In December, KSLLC submitted comments as follows regarding the significant delay in releasing 2017 funding for all applicants who filed and submitted applications for funding by June 30th and have not yet received funding – 8 months after submitting these applications.

Significant delay in funding for FY2017 is creating substantial undue hardship on health care providers across the nation and undermining the goals of the program

Rural health care applicants who depend on funding from the FCC's rural health care programs are in serious financial trouble with the standstill of funding for FY2017. Depending on each applicant's situation, they may be able to pay a portion of the charges but in most cases the service providers are not receiving payments for the services provided since July 1, 2017 and this is causing a very negative situation. The RHC Program participants are having to stretch their current budget for the unplanned cash needed to pay for the discount portion and in many cases, they simply do not have sufficient funds to pay.

The financial burden on the service providers may create a situation where service providers will be reluctant to continue service or drop out of the program completely. In these cases, we are losing one more provider that won't be submitting bids. This means that the RHC applicant may not receive any competing bids at all for services going forward.

Since these applicants have yet to be funded, the entities are faced with a conflicting legal situation. FCC and USAC instruction in January of 2018 has required the health care entities without prior approved Evergreen contracts to file again for competitive bids in FY2018. Many HCPs went to bid in FY2017 and after months of bidding, evaluating and negotiations, they signed binding multi-year contracts with service providers. Since FY2017 has not yet been funded or contracts approved Evergreen, the HCP must now compare them to new bids for FY2018. Upon conducting the bid evaluation process, HCPs are faced with cancelling their existing contracts and paying significant termination fees or bypassing funding for FY2018 because their contracted services are not the most cost-effective in the FY2018 process.

In both scenarios, the healthcare providers are placed in a financial situation that they did not anticipate and is unfairly punishing them for going to bid in FY2017, following FCC rules and signing multi-year contracts, as encouraged by the FCC. The HCPs do not have the funds for costly termination fees, nor can they afford to bow out of the program if they keep the contracts. This hardship is further compounded by the fact that the HCPs are in this very situation resulting from the FCC's own RHC Program rules.

It is imperative that the Funding Commitment Letters for FY2017 be sent immediately. Most HCPs do not have the funds to go forward with their projects for FY2017 without funding or an estimated timeline of funding commitments. Since the purpose of this Program is to further telemedicine and healthcare accessibility in the United States, the lack of funding for FY2017 is severely handicapping the goals of this Program.

16. Support for Increasing the Funding Cap Going Forward

As we stated in our initial comments, "Delivery of services using telehealth is becoming a necessity for providers and is no longer an optional service. Health care providers are seeking funding sources to afford quality telemedicine healthcare delivery. As these providers learn about the funding provided by the FCC's Rural Health Care programs, a significant increase in demand on the RHC program has and will continue to occur. The HCPs will continue to seek funding for the foreseeable future."

Based on our comments above, it is obvious that the fund needs to be increased to support the additional demand. The program is making such an important difference in the delivery of telehealth across the U.S. that restricting funding will significantly slow the implementation of services, leaving many rural citizens without healthcare services they require to survive and live productive lives.

We often hear people say, "we aren't saving babies here", but in this case, we really **are** saving not only babies but also entire populations of people bound to rural communities across America. In this technology-rich world we live in today, the solutions are there, the delivery mechanisms are there. We are just lacking sufficient funding to deliver the available solutions.

Most of commenters in this NPRM agreed that the lack of funding was holding them back from the delivery of the healthcare solutions and that the Fund needs to be increased. Below are a few examples that were included in the original submitted comments from February 2:

TeleQuality

> The bandwidth needs of TeleQuality's customers have increased drastically over the past few years. In 2013, the average bandwidth needed by a TeleQuality customer was 7 Mbps. Within a year, by 2014, that number had increased to 37 Mbps. And a year after that, in 2015, bandwidth needs of the average TeleQuality customer had increased almost tenfold, to 317 Mbps. TeleQuality's new customer contracts in funding year 2016 also show the increased demand for higher-bandwidth service: approximately 40 percent of new contracts in 2016 were for 100 Mbps or higher. [2]

New England Telehealth Consortium (NETC)

> The Commission Should Increase the Cap to Ensure Sufficient Funding for the RHC Program.
>
> As NETC works to realize the FCC's network-of-networks vision for health care, we believe it is important to recognize that the RHC program was created by Congress to do exactly what NETC is doing.

[2] TeleQuality (2018, February 2) Comments at 5, https://www.fcc.gov/ecfs/filing/102021748016O2

- Meet digital demands on healthcare
- Implement telehealth applications
- Capture and transmit PACS imaging,
- Implement and maintain EHRs,
- Address the Rural doctor deficit/shortage,
- Enable rural sites to access clinical urban specialties,
- Transition to cloud-based applications)

The Commission should conclude, for example, that growing demand for this funding is an opportunity to fulfill a clear Congressional objective, not a problem to be fixed. [3]

KSLLC added that another driver of demand is the RHC programs themselves as recapped below:

> A large driver of demand in the RHC fund are the new opportunities provided to all eligible providers under the Healthcare Connect Fund (HCF) program beginning in January 2014. The chart below is a comparison of eligible services under the HCF fund showing the differences between filing as an individual or filing as a consortium.
>
> When the ability to include urban providers in consortia became available, several large state agencies requested the new funds to connect with their outlying hospitals and clinics in one seamless network which enabled them to deliver more telehealth services than ever before.
>
> - HCPs have found that the HCF is a better solution because they can file as a consortium and include urban sites that provide essential services and resources for the rural sites.
> - They are also able to receive better pricing with volume discounts and the administrative burden is minimized by filing only one application instead of many.
> - Both individual and consortium HCPs also receive a flat 65% discount so the urban rate search is eliminated.
> - The HCF allows for more reliable budgeting for planning purposes regarding telemedicine circuits and network equipment for network operations and special construction of the network.
> - The added ability to request three years of funding on one application cuts down on administrative time and cost while still seeking the most cost-effective solutions.
>
> The advantages of the HCF Program has resulted in an increase in demand; however, it has also resulted in better telehealth services, both technically and through the facilitation of connecting more urban specialists with rural health patients needing care.
>
> The chart below summarizes the opportunities within the HCF program:

[3] New England Telehealth Consortium (2018, February 2) Comments at 5, https://www.fcc.gov/ecfs/filing/1020208600042

FCC HEALTH CARE CONNECT FUND[1]		
	INDIVIDUAL Applicants	**CONSORTIUM Applicants**
Eligible Services	Any advanced telecommunications or information service that enables HCPs to post their own data, interact with stored data, generate new data, or communicate, **by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.**	
Support provided	65%	65%
Reasonable & Customary Installation Charges (≤$5,000 undiscounted cost)	✓	✓
Lit Fiber Lease	✓	✓
Dark Fiber		
Recurring charges (lease of fiber and/or lighting equipment, recurring maintenance charges)	✓	✓
Upfront payments for IRUs, leases, equipment	NO	✓
Connections to Research & Education Networks	✓	✓
HCP Connections Between Off-Site Data Centers & Administrative Offices	✓	✓
Upfront Charges for Deployment of New or upgraded facilities	NO	✓
Eligible Equipment		
Equipment necessary to make broadband service functional	✓	✓
Equipment necessary to manage, control, or maintain broadband service or dedicated health care broadband network	NO	✓

18. Increasing the Cap, How Much?

With few exceptions, most commenters agreed that the cap should be raised above $400 million due to the evident increase in demand for delivery of health care in rural areas. However, not all commenters provided a suggestion for a specific amount of funds needed.

In KSLLC's initial comments, we stated that the fund should be raised to $800 million. This amount of funding was also recommended by the following commenters:

Schools, Health & Libraries Broadband (SHLB) Coalition:

> To ensure those statutory directives are met, we urge the Commission to increase the annual RHC spending cap from $400 to $800 million to reflect that the number of health care providers potentially eligible for the RHC program has more than doubled since 1997 when the $400 million cap was promulgated. [4]

Alaska Native Health Board (ANTHC)

> ANTHC suggests that, if the FCC keeps any cap in place, the base level of funding for the RHC Program be doubled to $800 million at a minimum. Additionally, the RHC Program should be adjusted in the future to account for inflation, which is, for instance, how the E-rate Program operates.[5]

Franciscan Alliance Inc. Parkview Health System, Inc. (The Commenters):

> Given the ever-increasing costs facing the healthcare industry the Commenters propose that the FCC: (1) establish an increased annual cap for the HCF Program of $800 million that is annually adjusted to CPI – Medical; and (2) reallocate funds among the various Universal Service Fund Programs. [6]

College of Healthcare Information Management Executives (CHIME):

> CHIME believes increasing the funds is warranted and should occur retroactively. We recommend that the cap be doubled to $800 million annually. For instance, the need to connect to skilled nursing facilities will drive the demand even higher. [7]

[4] SHLB (2018, February 2) Comments at ii, https://www.fcc.gov/ecfs/filing/102022402316613
[5] Biddle, Alaska Native Health Board (2018, February 1) Comments at 7, https://www.fcc.gov/ecfs/filing/10202217745150
[6] Franciscan Health Alliance and Parkview Health System (2018, February 2) Comments at 6, https://www.fcc.gov/ecfs/filing/10202882127370
[7] CHIME (2018, February 2), Comments at 2, https://www.fcc.gov/ecfs/filing/10202843503386

Other Ways to Fund the Demand

GDP Adjustment to Inflation:

Most commenters agreed with KSLLC that in addition to increasing the funding cap, the GDP-CPI should be used to adjust for inflation as is done in the E-rate program.

An illustration of the potential benefit to the RHC program is the recently announced 2018 rate of inflation for the E-rate program cited below:

On February 20, 2018, the Commission filed Public Notice DA-163 CC Docket No. 02-6 stating:

> Pursuant to section 54.507(a) of the Commission's rules, the Wireline Competition Bureau (Bureau) announces that the E-rate program funding cap for funding year 2018 is $4,062,030,726.2 The new cap represents a 1.8 percent inflation-adjusted increase in the $3,990,207,000 cap from funding year 2017. The Commission began indexing the funding cap to inflation in 2010 to ensure that E-rate program funding keeps pace with the changing broadband and telecommunications needs of schools and libraries.[8]
>
> The immediate effect this will have on the E-rate program is detailed in the footnote of the Notice as follows:
>
> > This represents a $71,823,726 increase for the E-rate program funding cap as a whole, including:
> >
> > $53,407,386 increase for the category one services funding level
> > $18,416,340 increase for the category two services funding level. [9]

19. Rollover of unused funds to subsequent funding years.

The suggestion that the Commission roll over unused funds annually as in the E-rate program received support from most commenters. Since KSLLC also files applications under the E-rate program, we have seen first-hand how beneficial these funds can be in enabling more applications to be fully funded. However, the resulting funds should be spread out over all filers matching the process with the E-rate program. Not subject to any prioritization.

Roll-over Unused Funds

20. As Kellogg & Sovereign® Consulting, LLC stated in initial comments:

> Funds should be provided in upcoming years without prioritization. In the E-rate program, unused funds have been essential in enabling more applicants to receive full funding for vital programs than they would have had without rollover of unused funds. The E-rate program applies the additional funds across the board rather than prioritizing distribution.

[8] Wireline Competition Bureau (2018, February 20) Comments at 1, https://www.fcc.gov/ecfs/filing/022033451576
[9] Ibid

Most commenters submitting replies regarding rolling over funds to subsequent years agreed with this recommendation.

Alaska Native Tribal Health Consortium (ANTHC) stated the following:

> ANTHC urges that the use of roll over funds not be limited to use in the next funding year but rather that these funds be made available for all subsequent funding years until the roll over funds are ultimately disbursed.[10]

USTELECOM

> In its discussion of the annual funding cap, the Commission requests comment on whether it should roll over unused RHC funds committed in one funding year into a subsequent funding year, as is done in the Commission's E-rate program USTelecom supports this proposal and urges the Commission to adopt it. ***11***

2. PRIORITIZING FUNDING IF DEMAND REACHES THE CAP

24. Prioritization Based on Rurality or Remoteness.

In Kellogg & Sovereign® Consulting's initial comments, we stated that "**Rurality** or remoteness alone does not indicate the highest need for funding. In the E-rate program, for example, the highest need is determined by the rural status of a school combined with the percent of low income students. Schools located in a rural area with a low income of 75% or greater receive the highest discount rates. This combination of rurality and low income effectively identifies the applicants with the greatest need."

TeleQuality cited the following in their original comments:

> TeleQuality recommends that committed funding be treated as it is in the E-rate Program: any unused committed funding should be carried forward for use in any subsequent funding year. This way, as demand increases, the small percentage of funds that remain unused will carry forward to the following year, and will likely be used by healthcare providers in the subsequent funding year. [12]

30. Modification of Term 'Rural'.

> KSLLC supports a definition of rurality that does not add additional complexity to the program. All standardized measures of funding should be evaluated and the ones that provide the most accurate depictions of actual rural healthcare entities without adding complexity to the determination should be used.

[10] Biddle, Alaska Native Tribal Health Consortium (2018, February 1) Comments at https://www.fcc.gov/ecfs/filing/10202217745150
[11] USTelecom (2018, February 5) Comments at 11, https://www.fcc.gov/ecfs/filing/1020200039827
[12] TeleQuality (2018, February 2) Comments at 7, https://www.fcc.gov/ecfs/filing/10202174801602

31. Prioritizing Based on Type of Service.

As stated in the original KSLLC comments

> We support the recommendation that the highest priority be given to services that support the primary purpose of Universal Service to provide affordable access. Therefore, the highest priority should be given to telecommunications and information services. Additionally, support for up-front costs and network build out should be a second priority as these one-time costs are often necessary to reduce costs of telecommunications and information services over the longterm.,

32. Priority based on HCF Program.

KSLLC

We promote the phase out of the Telecommunications Program to place all applicants on the same playing field, using unified rules and transparency. The HCF was developed over years of research and study with the Pilot Program and its principles provide the best support for Universal Service.

The statutory language of 47 U.S.C. §254(h)(1)(A) and § 254(h)(2)(A) of the Act gives specific instruction that was the basis for the creation of the Telecommunications Program; however, § 254(b)(7) states:

> *ADDITIONAL PRINCIPLES. --Such other principles as the Joint Board and the Commission determine are necessary and appropriate for the protection of the public interest, convenience, and necessity are consistent with this Act.*

KSLLC interprets this section to allow additional authority to the Commission, giving latitude for them to provide equal funding emphasis for the Healthcare Connect Fund. As stated in Item 22, funding should be disbursed first for essential services; however, we do not recommend setting aside or prioritizing certain amounts of funding for one or the other programs. Instead, we support phasing out the Telecommunications Program and continuing forward with one program.

CHRISTUS

CHRISTUS strongly recommends that the FCC consider going beyond its proposed harmonization of the two programs and collapse them into one. The need for two separate programs is no longer necessary when the same forms, timelines and policies can be used for both. The major difference is the method of calculating financial support which can remain as is. [13]

SHLB

…we support removing the Telecom Program from the existing $400 million cap – because the rural/urban price parity is statutorily mandated and thus should be uncapped – and maintaining the $400 million level of funding exclusively for the HCF.[14]

33. Prioritizing Based on Economic Need or Healthcare Professional Shortages

[13] CHRISTUS (2018, February 2) Comments at 2, https://www.fcc.gov/ecfs/filing/10202832220573
[14] SHLB (2018, February 2) Comments at ii, https://www.fcc.gov/ecfs/filing/102022402316613

KSLLC

We feel at this time, that a prioritization based on economic need or healthcare professional shortages would be too subjective and not possible to implement.

34. Prioritizing Funding with Shortages.

KSLLC

We recommend the following strategies to prioritize funding with shortages:

Phase out the telecommunications program. Now that majority of services are no longer subject to tariff rates, the determination of rural vs urban rates is subjective. As shown by recent FCC cases, the methodology is open to waste, fraud and abuse. The flat 65% discount rate in the health care connect fund protects the fund from manipulation of the urban and rural rates and allows for a reasonable discount to provide needed support. Additionally, phase out of the telecommunications program will result in administrative cost savings. The administrative burden on the RHC program of maintaining two separate programs is significant. Other commenters supported combining the two RHC programs as was stated earlier in this response (Christus, KSLLC, p. 8-9), and several commenters supported removing the Telecom program from the $400 million cap altogether.

2. TARGETING SUPPORT TO RURAL AND TRIBAL HEALTHCARE PROVIDERS

37. Rural health care consortium participation of 50% or more

KSLLC

In our experience working with 28 consortia over the past three years, we feel that the current requirement has worked well. Requiring a larger percentage would prevent some small consortia from receiving the benefits of being a part of a consortium.

38. We do not support eliminating the three-year grace period.

KSLLC

For new consortia, we have found that it typically takes longer than one or two years to establish the participants and ensure a proper balance. Many of these consortia are established due to a growth in their existing healthcare system, which sometimes takes several years to facilitate. Consortia leaders are typically located at the urban sites since they have the administrative support; therefore, the urban locations initiate the consortium and it takes at least three years to establish the contracts and then start adding rural participants.

39. Direct Healthcare-Service Relationship.

KSLLC

Including both urban and rural health care providers in the same consortium will, by definition, involve interaction of the health care professionals in support of telehealth throughout the organization. This relationship by its nature directly benefits the rural health care providers. Adding requirements for consortia to prove that urban providers are directly supporting the rural participants could negatively impact the collaborative nature and organic growth of a consortium. Therefore, we do not support any additional requirements to prove that the urban providers are directly supporting the rural participants.

SHLB

Some (commenters) have called for RHC funds to go only to those entities that are providing direct services to rural patients and should exclude funding to administrative centers and data centers. But these administrative and data centers provide direct support to the rural clinics. Without these centers, the rural provider would not be able to serve patients. The Commission's rules already require that the funds are used to support the provision of rural health services. Furthermore, the 2017 Briefing Book found that, of the 2705 entities who received support in 2016, only 152 were administrative or data centers (about 5.5%), so eliminating these entities from support would have a negligible impact on the availability of funds to other HCPs but would cause significant harm to the specific rural HCPs that rely upon the services provided by those administrative and data centers.[15]

American Hospital Association (AHA)

Requiring demonstration of a direct health care-service relationship between an HCF consortium's non-rural and rural health care providers that receive program support would be burdensome and likewise impose an undue burden on program participants. Implementing and enforcing reporting of a direct health care-service relationship would be difficult to administer, and any potential benefits would be far outweighed by the burdens imposed on applicants. Instead of introducing new administrative hurdles for potential consortia participants, the Commission should improve the processing of consortia applications and various HCF forms and streamline the treatment of individual health care sites. [16]

40. Rural and Tribal Healthcare Providers.

KSLLC

Targeted support for health care providers on tribal lands should continue to be an important priority of the program. Health care providers located on tribal lands represent a minimal but very important portion of the fund as these areas tend to be rural and underserved.

We agree with the AHA's comments below:

[15] SHLB (2018, February 2) Comments at ii, https://www.fcc.gov/ecfs/filing/102022402316613
[16] AHA (2018, February 2) Comments at 14, https://www.fcc.gov/ecfs/filing/10202389131049

AHA

The rural and remote nature of Tribal lands make telehealth services particularly powerful solutions for the vulnerable populations in those areas. Because the Indian Health Service is overextended and underfunded, the burden that Tribal lands place on adjacent health care providers is significant. Any additional support that can be provided to ensure the benefits of modern health care services reach Tribal populations should be provided and accounted for in the analysis of needed funding. [17]

1. CONTROLLING OUTLIER COSTS IN THE TELECOM PROGRAM -URBAN/RURAL RATE

41. URBAN/RURAL RATE:

We support the recommendations below regarding how the URBAN/RURAL rate should be determined.

ADTRAN

The Commission would modify the administration of the RHC Program so that USAC would be responsible for setting the urban rate used for determining the "comparable" to calculate the RHC subsidy amounts. ADTRAN believes such a change would improve the program. Rural health care providers lack the same level of expertise that USAC has with respect to knowledge of the telecommunications services market. Moreover, USAC can be completely objective in its assessments of the "comparables" - in contrast, a rural health care provider could have the incentive to manipulate its analyses in order to increase the subsidies to which it would be entitled under the subsidy based on "comparables." [18]

TeleQuality

TeleQuality believes that promoting competition in the rural healthcare market is the most powerful way to address potential rate manipulation. If the Commission or USAC establishes urban rates, the possibility of manipulation of the urban rates will essentially be eliminated. As for rural rates, once there is competition in rural markets, the rates will regulate themselves. To achieve this outcome, the Commission should encourage transparency in the RHC bidding process. Potential competitors should be allowed—as they are in the E-rate Program—to easily search for submitted applications, and HCPs should be required—as they are in the E-rate Program—to respond to all bona fide vendor questions and proposals. [19]

National Rural Health Association (NRHA)

NRHA believes that USAC is best positioned to determine the urban and rural rate standards. Health care providers are not well positioned, nor do they have the relevant expertise to determine these rates. While this activity is undeniably a resource intensive task, however, requiring the applicant to determine these rates results in a duplication of efforts since each applicant is required to determine this information. Furthermore, requiring this sort of intensive action on the part of the applicant, all

[17] Ibid
[18] ADTRAN (2018, February 2) Comments at 7, https://www.fcc.gov/ecfs/filing/1020255434740
[19] TeleQuality (2018, February 2) Comments at 2, https://www.fcc.gov/ecfs/filing/10202174801602

but ensures that they cannot complete their application without outside assistance, creating a further barrier for the most disadvantaged applicants. [20]

1. Controlling Outlier costs in the Telecom Program

42. Outlier Funding Requests enhanced review

KSLLC agrees with the comments filed as follows:

TeleQuality

If the Commission pursues an "enhanced review" approach …., it should set clear standards for USAC to follow. The standards should be transparent, so HCPs are not guessing as to how their applications will be judged, and any denial or reduction of funding should be accompanied by a thorough explanation. The benchmark should include a specific dollar component. If the dollar amount is below a certain threshold, then there should be no enhanced reviews. [21]

AHA

While attempting to identify outlier funding requests to apply a heightened review of such requests may make sense on the surface, the Commission should proceed cautiously before establishing benchmarks and using them to automatically reduce the amount of support provided to certain HCPs. At most, the use of benchmarks should be used to apply an enhanced review process to such applications to ensure applicants have justified their funding requests. The service costs of some applicants, as the Commission has correctly recognized, are "legitimately high due to their unique geography and topography," and are also due to a variety of other demographic, cultural, and practical factors, including pricing, the number of providers receiving funds, and the level of connectivity required. [22]

2. DEFINING THE "COST-EFFECTIVENESS" STANDARD ACROSS THE RHC PROGRAMS

82. Cost-Effectiveness Standard

KSLLC stated in their comments regarding 'cost-effectiveness' the following:

We believe the Commission should implement the use of the current HCF competitive bidding requirements as outlined in the HCF Order in §54.642 4(c)^3 for all RHC participants. These requirements are complete and would provide additional bid requirements not currently existing in the Telecommunications Program. This would bring the two programs closer together and provide vendors with clear guidelines for both RHC programs.

[20] NRHA (2018, February 2) Comments at 4, https://www.fcc.gov/ecfs/filing/10202090603917
[21] TeleQuality (2018, February 2) Comments at 14, https://www.fcc.gov/ecfs/filing/10202174801602
[22] AHA (2018, February 2) Comments at 15, https://www.fcc.gov/ecfs/filing/10202389131049

US Telecom

USTelecom agrees with the Commission that the RHC bid evaluation and cost- effectiveness standards merit revision. In doing so, USTelecom recommends that the Commission consider applying to the RHC Program principles for bid evaluation and cost- effectiveness that apply today to the E-rate program.

Specifically, USTelecom recommends the Commission consider mandating RHC Program applicants to conduct open, transparent procurement processes similar to those that apply to E-rate applicants today, by providing additional information, either in the FCC Form 465 or in a publicly available Requests for Proposals (RFPs) regarding the services they require, as well as their anticipated usage demands.

USTelecom also suggests that the Commission align the competitive bidding standards for the Telecom Program with those applicable to HCF, including the obligation to conduct a fair and open competitive bidding process. Additionally, USTelecom recommends that the Commission adopt for the RHC Telecom Program the HCF mandate that price be a primary factor in bid evaluations and that the bid selected be the most cost-effective service offering. [23]

ADTRAN commented:

The *RHC NPRM* proposes to align the "fair and open" competitive bidding standard across all USF programs in order to enhance transparency, increase administrative efficiency, and ensure that the benefits of the subsidy dollars are maximized.

ADTRAN also supports this proposal. The service providers and USAC are familiar with the rules, so applying the rules across the different programs would more easily allow a service provider to bid to provide service across all of the USF programs. The greater participation by more providers in turn should lead to a decrease in prices as a result of the increased competition. Moreover, health care providers, service providers, USAC and the FCC all benefit from there being clear rules of the road, rather than the risk of inconsistent precedent/standards for the various USF programs. And ADTRAN can conceive of no good reason to apply different "fair and open" bidding standards to the RHC program. This is another common-sense improvement to the RHC Program that the Commission should adopt. [24]

TeleQuality

TeleQuality also agrees with the Commission's proposal to adopt the gift rules applicable to E-rate participants. The E-rate rules seem to be generally understandable to Program participants, and should suffice without additional restrictions specific to the RHC Program.
In addition, the Commission seeks comment regarding whether the "fair and open" standard should be adopted for the Telecom Program and whether the competitive bidding exemptions that apply in the HCF Program should also apply for the Telecom Program. TeleQuality believes they should.

[23] USTelecom (2018, February 2) Comments at 18, https://www.fcc.gov/ecfs/filing/1020200039827
[24] ADTRAN (2018, February 2) Comments at 8, https://www.fcc.gov/ecfs/filing/1020255434740

Furthermore, TeleQuality believes the Commission should make clear that "fair and open" means that HCPs must respond to questions about the HCP's service needs from all potential bidders.[25]

84. Detailed Requests

KSLLC stated:

We support a requirement that all RHC participants be required to provide specific, detailed information on their needs for eligible services in their RFP and /or requests for services. All applicants should also provide the same amount of transparency that the HCF program currently requires for the bidding process. For example, all HCPs should use a scoring matrix to evaluate all bids and provide copies of all bids received during the competitive bidding period. All scoring matrices and bids should be included at the time of the funding request as is required in the HCF. For administrative efficiency and timeliness of funding, the program administrator will need to have discretion over the internal procedures used to manage in-depth analysis of information submitted and approval of funding based on internal review standards.

USTELECOM

Specifically, USTelecom recommends the Commission consider mandating RHC Program applicants to conduct open, transparent procurement processes similar to those that apply to E-rate applicants.

Typically, today, the applicant may specify only that it requires telecommunications services for, by way of illustration, "sending and receiving medical billing info, files and/or images to and from remote locations, patient videoconferencing, medical administration, and telemedicine." Even though the FCC Form 465 now includes a matrix of applications and usage level ("light/moderate/heavy") categories, additional detail would enable service providers and applicants alike to assess their service needs more accurately. USTelecom suggests that it would help ensure meaningful bid evaluation and cost effectiveness review for the applicant to include additional information in the FCC Forms 465.[26]

87. & 88. Consultants and Service Providers

KSLLC

We applaud the Commission's proposal to adopt specific requirements that will give consultants well- defined boundaries as they guide applicants through the HCF Program funding process.

The E-rate program has included compliance in all training programs for applicants, consultants and service providers since 2010. This training includes and clearly states the role of Applicants, Service Providers, and Consultants regarding each type of entity and their role:

- **Applicant Role**
  - Write technology plan, prepare federal competitive bidding forms and request for proposals, evaluate bids, select provider, document the process, file forms for funding support, and select invoicing method

[25] TeleQuality (2018, February 2) Comments at 24, https://www.fcc.gov/ecfs/filing/10202174801602
[26] USTelecom (2018, February 2) Comments at 18, https://www.fcc.gov/ecfs/filing/1020200039827

- **Service Provider Role**
  - Respond to competitive bidding requests, provide vendor documentation, provide technical answers on questions regarding specific goods and services requested, (but NOT on competitive bidding); submit invoices as directed to program administrator
- **Consultant Role**
  - Follow the role of their client – either applicant ***or*** service provider

In 2010, the E-rate program began requiring consultants to apply for and use a Consultant Registration Number (CRN). Applicants then enter the CRN in their online forms to provide transparency on all E- rate applications.

USAC guidance in 2014 provided the following information regarding the role of the consultant as follows:

- Obtain a Consultant Registration Number to be included on all FCC forms where assistance is provided to schools and libraries with their E-rate applications for a fee.
- Follow the role of your client – either applicant or service provider.
- Avoid conflicts of interest.
- Document your compliance with FCC rules on an on-going basis.
- Retain documentation for at least five (now 10 years) from last date of service delivery.

b. ESTABLISHING CONSISTENT GIFT RESTRICTIONS

89. & 90. Gift Rules.

KSLLC

We support the adoption of gift restrictions that are applicable year-round. This avoids "grey areas" in gifting throughout the year. We also support a certification by applicants that they have not solicited or accepted a gift or any other thing of value from their selected service provider or any other service provider participating in their competitive bidding process. We support rules that will also require a certification from the service providers as well.

91. Codify Gift Restrictions.

KSLLC

We agree that the FCC should codify gift rules for the RHC programs like the rules established for the E-rate program and federal entities. Once clearly outlined gift rules are implemented, applicants who receive offers from service providers can point to clear rules that allow them to say no and avoid questionable activity that might influence their buying decisions. Gift rules should apply to applicants, service providers, and consultants.

US Telecom

Since 2010, the Commission has prohibited E-rate applicants' from soliciting or accepting any "gift, gratuity, favor, entertainment, loan, or any other thing of value from a service provider participating

in or seeking to participate" in the E-rate program.27 The Commission's rules similarly prohibit service providers from offering or providing E-rate applicants with such gifts.28 The Commission indicates that "[a]lthough there is no specific rule in the RHC Program, a gift from a service provider to an RHC applicant is nonetheless considered to be a violation of the Commission's competitive bidding rules. . . ."29 Because this is not codified, as it is for E-rate, USTelecom is concerned that not all RHC applicants, consultants or service providers are even aware of this gift restriction, let alone have complied with it. Codifying this rule, as the Commission proposes, is a necessary step to eliminate fraud and abuse in the RHC Program.[27]

We support extending the E-rate rule, as is, to the RHC Program.

SHLB

We support further measures to guard against waste, fraud and abuse – such as harmonizing RHC program rules on gifts and consultants with the E-rate program – however we believe these steps should be taken simultaneously with a cap increase as the demand for greater broadband connectivity will continue to expand due to changes in the healthcare marketplace and federal mandates regarding electronic health records.[28]

96. Streamlining FCC Forms.

We recommend that the FCC streamline the forms as recommended in the NPRM below:

…we propose condensing the RHC Program application process to use fewer online FCC Forms. We propose to use four forms—

- Eligibility Form,
- Request for Services Form,
- Request for Funding Form,
- and Invoicing/Funding Disbursement Form.

Applicants could use the same online form whether applying under the Telecom or HCF Programs by indicating on each online form under which RHC Program they seek funding for services Applicants thus would no longer have to switch between the online forms when applying for services under both the HCF and Telecom Programs.

We fully support the recommendation to simplify the forms.

Additionally, the continuation of the Telecommunications Program creates an undue burden on the administration of the program. Phasing out the telecommunications program would greatly alleviate the multiple forms issues that are being managed by the limited staff and the program stakeholders.

[27] USTelecom (2018, February 2) Comments at 19, https://www.fcc.gov/ecfs/filing/1020200039827

[28] SHLB (2018, February 2) Comments at ii, https://www.fcc.gov/ecfs/filing/102022402316613

98. Consortia Processing Applications

We support SHLB statements that the Commission improve the processing of consortia applications and find ways to speed the processing of the various FCC HCF forms and streamline the treatment of individual health care sites. The 8-month delay for FY 2017 applications has created a huge financial burden on HCPs, most who are already struggling financially.[29]

3. APPLYING LESSONS LEARNED FROM THE HCF PROGRAM TO THE TELECOM PROGRAM

100. Aligning the "Fair and Open" Competitive Bidding Standard

We agree that the Commission should align the "fair and open" competitive bidding standard applied to each Program. We also support the application of the "fair and open" standard to all participants under each RHC Program, including applicants, service providers, and consultants, and require them to certify compliance with the standard.

3. Aligning Competitive Bidding Exemptions in Both RHC Programs

101. Aligning Competitive Bidding Exemptions in Both RHC Programs

102. Exemptions.

We support the phase out of the Telecommunications Program which would eliminate the duplicate processes currently managed by the limited administrative staff. During the phase out period, we support the alignment of all rules for both RHC programs as stated several times above. In doing so, they should also adopt the E-rate program guidelines which have been successfully implemented during the past twenty years of the E-rate program.

93. Competitive Bidding Documentation.

102. Requiring Submission of Documentation with Funding Requests[30]

KSLLC

> If the Telecom remains a separate program form a combined Telecom/HCF we support requiring "Telecom Program applicants to provide, contemporaneously with their requests for services (i.e., FCC Forms 465 and/or RFPs), certifications attesting to their compliance with Telecom Program rules, bid evaluation criteria and worksheets demonstrating how they will select a service provider, and a declaration of assistance (if applicable)."

Combining the two programs would eliminate a separate requirement for each fund.

[29] Ibid

103. Requiring Submission of Documentation with Funding Requests

KSLLC

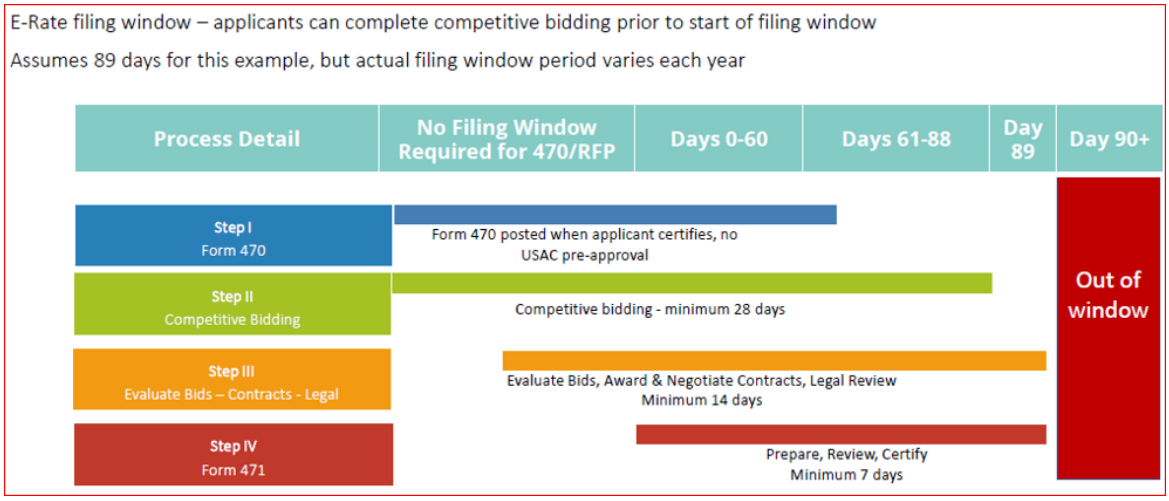
Again, we emphasize our support for phasing out the Telecommunications Program to put all participants on the same level playing field for accountability. We support codifying filing documentation requirements for all RHC participants that matches the requirements for the HCF Program to improve uniformity and transparency.

e. Unifying Data Collection on RHC Program Support Impact

4. Managing Filing Window Periods

106. Filing Windows.

KSLLC supports the continuation of the current filing window period established by the Bureau and USAC for administering FY 2017 HCF Program funds with set filing periods make it easier for the applicant to plan accordingly, except that Applicants should be able to post RFPs and funding requests beginning 6 months before the filing window opens to give applicants time to more thoroughly review bids received and provide ample time for the applicants to complete contracts prior to the window closing like is done in the E-rate program. See the chart below:



TeleQuality

TeleQuality believes that the filing window process established by the Wireline Competition Bureau and USAC is acceptable, but HCPs should be allowed to seek bids earlier than January 1 of a funding year so the bidding process timeframe is not so short. As noted above, timely commitments should be one of the Program's primary goals.[31]

[31] TeleQuality (2018, February 2) Comments at 23, https://www.fcc.gov/ecfs/filing/10202174801602

The Franciscan Alliance Inc. and Parkview Health System, Inc. stated:

> …for filing window periods adopted by the FCC for all future funding years under the RHC Program, the Commenters propose that the filing window periods be fixed well in advance of any upcoming filing year so that applicants may plan their program participation accordingly. Also, the Commenters propose that the FCC consider a way to shorten the time between the close of a funding window period and the issuance of Funding Commitment Letters ("FCLs").[32]

USTelecom urges the Commission to:

> (2) establish a consistent year-to-year schedule of funding period windows, with the first closing sufficiently in advance of the July 1 beginning of the funding year so that USAC can issue all funding decisions before the new funding year starts;
>
> (3) eliminate current rules that limit applicant's submission of requests for service (FCC Form 461 and FCC Form 465) to a strict timeframe starting on January 1st and, instead, like in the E- rate and in line with normal market practices, allow applicants to conduct their RFP processes on a rolling timeframe (3) direct USAC to issue decisions on all funding requests filed in that first window on a rolling basis (even if exact dollar amounts need to await the results of *pro rata* calculations), with all such decisions released by June 1, shortly before the beginning of that funding year, to give healthcare providers and service providers time to install and activate telecommunications services before July 1; and (4) require USAC to provide periodic (*e.g.*, weekly) updates on its progress in processing funding requests during and after the filing windows as long as funding requests are pending.[33]

Transparency:

KSLLC

> The request for Transparency in this NPRM is mentioned several times in various places. To make it easier for reviewers to view comments directly related to transparency, we have added a separate category to our comments.
>
> The lack of USAC transparency negatively impacts applicants which makes it difficult to adhere to USAC statutes, rules and procedures.
>
> As an illustration, the data that is required for submission within the portal is not available without the HCP or consultant drilling down into multiple layers of the Portal.
>
> For instance, to access FCC Form 461's from a particular year, a user cannot filter by document name/number and pull all 461s for that year. The process requires going into each HCP individually and clicking through three menus to then download the 461 as a PDF and view the information contained in the 461. The data from the PDF documents is not in an open format that can be extracted and put into a usable format.

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[32] Franciscan Alliance Inc, Parkview Health System, Inc. (2018, February 2) Comments at 17, https://www.fcc.gov/ecfs/filing/10202882127370

[33] USTelecom (2018, February 2) Comments at 21, https://www.fcc.gov/ecfs/filing/1020200039827

All information from each of the FCC forms in both RHC programs must be individually downloaded, viewed, extracted and manually put into independent spreadsheets or databases to obtain usable information for HCPs. As an example, if an HCP would like to know how much funding they were awarded in a given fund year, the HCP must access their Funding Commitment Letters, sometimes 10 or more for each fund year, then manually calculate their approved funding from each FCL. In the E-rate program there is an open data platform that can be accessed to manipulate and analyze data using multiple criteria.

As the USF is all funded by fees assessed by the FCC and passed on to ratepayers by their carrier, this data should be made available for the RHC programs in the same manner. The E-rate program has already deemed the information to be publicly available and we find no law in place that distinguishes protection to the data in the RHC Programs.

ADS

All RHCP data should be available to the public (such as the Schools and Library Division ("SLD") Data Retrieval Tool), allowing better understanding of the data. Organizational types could be tracked on the application and included in a reporting structure. We look forward to utilizing the USAC Open Data website and interacting with USAC to upload data directly to USAC systems. API technology (JSON) could be utilized to send raw data for all fields of an Application or Form.
The creation of an Eligible Technologies Service List and Eligible Locations List would help provide transparency and eliminate waste fraud and abuse by removing questions concerning the services and functionality performed at locations available for support. Eligibility lists could set expectation as to what beneficiaries may seek and provide guidance as to what service providers may propose.[34]

US Telecom

To permit meaningful review of applicants' funding requests that seek to rebut this presumption of reasonable comparability, the Commission should direct USAC to make all funding requests public and searchable. Already, FCC Forms 462 and 466 alert users on their face that, "Information requested by this form will be available for public inspection." Today, USAC has not implemented that commitment. Rather, USAC publishes only the total amount of each funding commitment, but no information on the specific services the applicant purchased, the urban rate the applicant will pay, or the competing bids that were rejected. USAC's actions are inconsistent with the representations regarding public inspection contained in FCC Forms 462 and 466.

The Commission should extend to the RHC Program its determination in the E-rate Modernization Order that the need for pricing transparency of subsidized services would be best served by making information regarding the specific services and equipment purchased by schools and libraries, as well as associated retail pricing, publicly available on USAC's website for funding year 2015 and beyond.

Thus, pursuant to that order, in the E-rate program, all applicants' funding requests (FCC Form 471) are posted on USAC's website in an open data platform that can be searched by the general public, including other applicants, service providers, academics and third parties at large. The decision to make this information publicly available injected transparency into the E-rate program as a catalyst

[34] ADS Advanced Data Services, Inc. (2018, February 2) Comments at 2, https://www.fcc.gov/ecfs/filing/10203287939262

for increased competition, and, among other things, enhanced review of the cost-effectiveness of purchased supported services.

Thanks to this Commission directive and the open data platform that USAC has developed, today, the public is armed with robust, searchable data tools that include essential data provided by applicants to USAC contained in FCC Form 470 (outlining the services sought) and FCC Form 471 (requesting funds for eligible E-rate services), including the types of services rendered at a given location, associated prices and service providers delivering the service.

Importantly, USAC's E-rate open data platform includes effective export data tools that allow third parties to evaluate the data. The RHC Program requires at least this level of transparency, particularly considering the extraordinary waste, fraud, and abuse in the Telecom Program. Making RHC funding requests publicly available and readily searchable will allow interested parties (the selected service provider, competitors, other healthcare providers, academics, government watchdogs, consultants) to analyze the reasonableness of the request and will promote increased competition in this program.

USTelecom urges the Commission to direct USAC to undertake similar efforts to create an open data platform for the RHC Program. [35]

TeleQuality

The *Notice* seeks comment on proposals designed to "reduce opportunities for manipulating rates." TeleQuality believes that promoting competition in the rural healthcare market is the most powerful way to address potential rate manipulation. If the Commission or USAC establishes urban rates, the possibility of manipulation of the urban rates will essentially be eliminated. As for rural rates, once there is competition in rural markets, the rates will regulate themselves. To achieve this outcome, the Commission should encourage transparency in the RHC bidding process. Potential competitors should be allowed—as they are in the E-rate Program—to easily search for submitted applications, and HCPs should be required—as they are in the E-rate Program—to respond to all bona fide vendor questions and proposals.

USTELECOM

USAC application processing times today are woefully inadequate to meet the needs of healthcare providers, or to satisfy the requirements of Section 254. Under the statute, support must be "specific, predictable and sufficient" to preserve and advance the universal service goals of the statute.30 After unexpectedly lengthy delays in issuing funding year 2016 commitments, new USAC leadership pledged improvements in both speed and transparency for Funding Year 2017. But, with over seven months of funding year 2017 behind us, USAC has issued no funding commitments whatsoever, and applicants are in the dark as to when (or whether) they may receive decisions on their funding requests. In many cases, service providers have delivered contracted services in good faith for seven months, accumulating large accounts receivable balances, with little or no incoming revenue in return. In other cases, healthcare providers have asked to postpone their service start

[35] USTelecom (2018, February 2) Comments at 16, https://www.fcc.gov/ecfs/filing/1020200039827

dates, while they wait to see what level of financial commitment they will eventually incur. The program is on the wrong track. These egregious delays themselves undermine the RHC Program's mission.

SIGNING FORMS

TeleQuality recommends that the Commission consider requiring the applicant itself to sign the FCC Form 466, rather than allowing a consultant to sign it. The Commission might also consider adding certification requirements for the HCP itself, such as a declaration by the HCP applicant that it has evaluated all bids and ensured an open and fair competitive bidding process. This kind of skin in the game will help the Commission ensure that the HCP is sufficiently vested in the competitive bidding process. [36]

CONCLUSION

Kellogg & Sovereign® Consulting, LLC appreciates the opportunity to submit these comments. We hope that they will be helpful in determining changes that would make the RHC programs better able to meet the needs of the healthcare providers in providing services that will directly impact the health needs of "Rural America."

Sincerely,

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[36] TeleQuality (2018, February 2) Comments at 12, https://www.fcc.gov/ecfs/filing/10202174801602